New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35a000	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLERS MILL SENIOR LIVING	1674 DELSEA DRIVE DEPTFORD, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00177021 CENSUS: 45 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/07/25

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint#: NJ00177021

Based on interview and record review, it was determined that the Executive Director (ED) failed to implement and enforce the facility policy titled, "Missing Resident - Elopement Prevention Program" to ensure the safety of the facility's NJ Ex Order 26.4b1 residents who have the potential to [redacted], for 1 of 3 residents reviewed for [redacted], Resident #2. An Imminent Danger (ID) was identified. This deficient practice was evidenced by the following:

On 9/16/2024 at 2:23 p.m., the New Jersey Department of Health received a Facility Reportable Event (FRE), which revealed that on NJ Ex Order 26.4b1 p.m., Resident #2 [redacted] from the facility's NJ Ex Order 26.4b1, due to the lock of the exit door malfunctioning. The ID was reported to the Licensed Assisted Living Administrator on 9/24/24 at 12:00 p.m. about the above issues.

1. On 9/24/2024 At 10:04 a.m., the surveyor reviewed the facility's policy titled, "Missing Resident - Elopement Prevention Program" which revealed, "... Resident Assessment and Interventions for Managing Elopement Risk ... 2. Incident reports and regulatory required reports are completed when elopement and missing resident events occur."

At 10:06 a.m., during the survey, the surveyor interviewed the facility's Director of Health and

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A 310	Continued From page 2 Wellness Nurse (HWN) who stated that she did not have an investigation or incident report related to Resident #2's NJ Ex Order 26.4b1 which took place on NJ Ex Order 26.4b1. The HWN later at 10:14 a.m., stated to the surveyor that the facility's ED would email the surveyor the investigation related Resident #2's NJ Ex Order 26.4b1. At 1:00 p.m., during surveyor interview with the facility's HWN, the surveyor informed the HWN that the surveyor did not receive an email from the facility's ED that contained the incident report, or an investigation. At that time, the HWN stated that she was unable to provide the surveyor with an incident report or investigation. The surveyor did not receive an incident report or investigation related to Resident #2's NJ Ex Order 26.4b1 at the time of the survey. On 9/25/2024 at 9:09 a.m., post survey, the surveyor received an email from the facility's ED containing a document titled, "Resident Incident Report" that included an Incident Investigation. The Resident Incident Report which was signed by the facility's HWN at NJ Ex Order 26.4b1 p.m. and signed by the facility's ED at NJ Ex Order 26.4b1 4 a 8:59 a.m., post survey. 2. On 9/24/2024 At 10:04 a.m., while conducting an FRE survey, the surveyor reviewed the facility's policy titled, "Missing Resident - Elopement Prevention Program" which revealed, " ... Resident Assessment and Interventions for Managing Elopement Risk ... 6. The Executive Director/Designee is responsible for Elopement, missing resident event review and identification of opportunities for improvement. This includes follow up communication and employee training compliance for identified improvements.	A 310		

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A 310	Continued From page 3 At 11:11 the surveyor reviewed Resident #2's Electronic Medical Record (EMR), which did not reveal an NJ Ex Order 26.4b1 completed on Resident #2's admission date of NJ Ex Order 26.4b1. The surveyor reviewed the resident's Face Sheet which revealed Resident #2 had an Admission date of NJ Ex Order 26.4b1 and diagnosis which included NJ Ex Order 26.4b1. The EMR also revealed a document titled, "Progress Notes", which revealed a Note dated NJ Ex Order 26.4b1 and timed at 2:33p.m., which revealed that Resident #2 NJ Ex Order 26.4b from the facility's NJ Ex Order 26.4b1 due to an exit door mag [magnetic] lock malfunctioning. At 1:00 p.m., during surveyor interview with the facility's HWN, the HWN stated that she educated the facility's staff but was unable to provide the surveyor with documentation of the education provided to the facility's staff after Resident #2's NJ Ex Order 26.4b1 The Removal Plan was requested, received and accepted on 10/31/24 that included an NJ Ex Order 26.4b1 done for Resident #2, receipt of the work order for the door, copies of the daily door log checks, receipt of the incident report, inservices to all staff concerning the elopement policy, copies of the staff mass notification and the surveyor observed the door was repaired and alarmed onsite.	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences,	A 401		

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A 401	Continued From page 4 comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint#: NJ00177021 Based on interview and record review, it was determined that the facility failed to ensure that the resident's right for safety was maintained for all facility residents. An Imminent Danger (ID) was identified. This deficient practice was evidenced by the following: On 9/16/2024 at 2:23 p.m., the New Jersey Department of Health received a Facility Reportable Event (FRE), which revealed that on NJ Ex Order 26.4b1 m., Resident #2 NJ Ex Order 26.4b1 from the facility's NJ Ex Order 26.4b1 due to the lock of the exit door malfunctioning. The FRE also revealed that a couch was placed in front of the door that malfunction to deter the residents from attempting to leave. The ID was reported to the Licensed Assisted Living Administrator on NJ Ex Order 26.4b1 p.m. about the above issues. At 11:11a.m., the surveyor reviewed Resident #2's Electronic Medical Record (EMR), which did not reveal an NJ Ex Order 26.4b1 completed on Resident #2's admission date of NJ Ex Order 26.4b1 The surveyor reviewed the resident's Face Sheet	A 401		

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A 401	Continued From page 5 which revealed Resident #2 had an Admission date of NJ Ex Order 26.4b1 and diagnosis which included NJ Ex Order 26.4b1 [redacted]. The EMR also revealed a document titled, "Progress Notes", which revealed a Note dated NJ Ex Order 26.4b1 and timed at 2:33p.m., which revealed that Resident #2 NJ Ex Order 26.4 from the facility's NJ Ex Order 26.4b1 [redacted] due to an exit door mag [magnetic] lock malfunctioning. On 9/24/2024 at 11:15 a.m., the surveyor interviewed the facility's Director of Maintenance (DM) who stated that on NJ Ex Order 26.4b1, he was called into the facility due to a door not locking which resulted in Resident #2 NJ Ex Order 26.4b1 During continued surveyor interview, the DM stated that when he arrived at the facility, there was a couch in front of the door. The DM also stated he removed the door and fixed the latch so that the door would lock and reset the door alarm. The DM also stated that the facility doors are checked by him monthly. At 11:45 a.m., the facility's DM provided the surveyor with documents titled, "Fire Doors and Windows: Inspection - Latch and Gap" which revealed the MD inspected the back door in which Resident #2 NJ Ex Order 26.4b1 and checked off that the door passed his physical inspection. The couch being in front of the door posed a fire safety hazard to all facility residents. The door lock malfunctioning resulted in an elopement and put all residents who were an elopement risk, at risk for elopement. The Removal Plan was requested, received and accepted on 10/31/24 that included NJ Ex Order 26.4b1	A 401		

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A 401	Continued From page 6 NJ Ex Order 26.4b1 done for Resident #2, receipt of the work order for the door, copies of the daily door log checks, receipt of the incident report, inservices to all staff concerning the elopement policy, copies of the staff mass notification and the surveyor observed the door was repaired and alarmed onsite.	A 401		
A 707	8:36-7.2(c) Resident Assessments and Care Plans (c) If the initial assessment in N.J.A.C. 8:36-7.1(a) indicates that the resident requires health care services, a health care assessment shall be completed within 14 days of admission by a registered professional nurse using an assessment instrument available from the Department, or an assessment instrument that has been adopted by the facility or program, equivalent to the instrument available from the Department, and which meets the requirements of (d) below. This REQUIREMENT is not met as evidenced by: NJ00177021 Based on interview and record review, it was determined that the facility failed to ensure that the NJ Ex Order 26.4b1 resident was completed upon admission to the facility for 1 out of 3 residents reviewed for NJ Ex Order 26.4b1, Resident #2. An Imminent Danger (ID) was identified. This deficient practice was evidenced by the following: On 9/24/2024 at 9:39 a.m. while conducting a Facility Reportable Event surveyor, the surveyor	A 707		

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A 707	Continued From page 7 interviewed the facility's Director of Health and Wellness Nurse (HWN) who stated that Resident #2 NJ Ex Order 26.4b1 [redacted] due to one of the facility's secured door lock malfunctioning. The ID was reported to the Licensed Assisted Living Administrator on NJ Ex Order 26.4b1 00 p.m. about the above issues. At 10:04 a.m., the surveyor reviewed the facility's policy titled, "Missing Resident - Elopement Prevention Program" which revealed, "...Resident Assessment and Interventions for Managing Elopement Risk ... Elopement risk assessments are completed for Memory support residents upon move-in, change of condition and with the community regulatory required assessment schedule ..." At 11:11 a.m., the surveyor reviewed Resident #2's Electronic Medical Record (EMR), which did not reveal NJ Ex Order 26.4b1 [redacted] completed on Resident #2's admission date of NJ Ex Order 26.4b1. The surveyor reviewed the resident's Face Sheet which revealed Resident #2 had an Admission date of NJ Ex Order 26.4b1 and diagnosis which included NJ Ex Order 26.4b1 [redacted]. The EMR also revealed a document titled, "Progress Notes", which revealed a Note dated NJ Ex Order 26.4b1 and timed at 2:33p.m., which revealed that Resident #2 NJ Ex Order 26.4b1 [redacted] due to a exit door mag [magnetic] lock malfunctioning. At 11:39 a.m., during surveyor interview, the surveyor requested the facility's HWN provided the surveyor with Resident #2's NJ Ex Order 26.4b1 [redacted]	A 707		

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A 707	Continued From page 8 At 1:00 p.m., the surveyor received requested NJ Ex Order 26.4b1 from the facility's HWN that did not include NJ Ex Order 26.4b1 rom Resident #2 admission date. The HWN only provided the surveyor with NJ Ex Order 26.4b1 At that time the surveyor interviewed the facility's HWN who stated that she did not see an NJ Ex Order 26.4b1 for Resident #2 at the time of admission. The Removal Plan was requested, received and accepted on 10/31/24 that included NJ Ex Order 26.4b1 done for Resident #2, receipt of the work order for the door, copies of the daily door log checks, receipt of the incident report, inservices to all staff concerning the elopement policy, copies of the staff mass notification and the surveyor observed the door was repaired and alarmed onsite.	A 707		

TYLERS MILL
Senior Living
1674 Delsea Drive I Deptford, NJ 08096 I 856.384.7750 I TylersMillSeniorliving.com

A310 8:36-3.4(a)(1) Administration
Complaint: NJ00177021

How the plan of correction will be accomplished

- Executive Director (ED) will ensure that all employees follow and implement the policy for "Missing Resident-Elopement Prevention Program" and the policy for "Internal Incident Reports and State Reports" to prevent the reoccurrence of elopements in Memory Care Building number one. Resident Rights will continue to be posted in a conspicuous area at the entrance of Memory Care Building number one as well as in Building number 2, and all employees will be educated on all Resident Rights.

How the Community will identify other residents having the potential to be affected by the same deficient practice

All residents in Memory Care Building number one, have the potential to be affected by the deficient practice:

- Director of Health and Wellness (DHW) completed the incident report on 9/25/2024 upon her return to work after being on PTO and will continue to ensure that all incident reports used for internal use and assessments, including and not limited to elopements are documented.
- HWD/RN to complete a resident elopement assessment upon move-in, semi-annually and with change in condition when diagnosis states suspected cognitive impairment.
- HWD/RN to determine resident's risk for elopement using the Elopement Risk Assessment which may include information from the resident's healthcare provider, family/responsible party, or past communications and observations. The Elopement Risk Assessment is filed in the resident's medical record.
- ED/HWD/RN and/or designee to audit all residents' charts and enforce residents' specific interventions, for residents identified at risk for elopement and documented on the resident's Service Plan. Ongoing for new residents or residents with changes in condition.
- ED/HWD and/or Designee will ensure that all employees are educated on Resident Rights and "Missing-Resident Elopement Prevention Program", policy.

Accepted 2/7/25

What systemic measures have been put in place to ensure that the deficient practice will not recur

- The Director of Plant Operations (DPO) will continue to perform daily door and lock checks on business days and Caregivers will continue to perform door and lock checks on weekends.
- ED, DPO and/or Designee will ensure that all doors are maintained and completely secure to ensure that Resident# 2 and all residents are not in imminent danger.
- ED/HWD or designee to ensure that a resident color photograph, a copy of the resident's emergency face sheet and completed advance directive documents, are maintained in the Elopement binder. An additional copy located in the community bus (if residents at risk of elopement ride the bus) and the Wellness Center. Photographs to be updated annually or upon a resident change in condition which may affect resident physical appearance. All staff are made aware of the location of each elopement binder by the Executive Director.
- ED/HWD or designee to ensure elopement training is provided upon hire, during new hire orientation and annually. ED/HWD or designee will ensure that elopement drills are conducted each month to ensure quarterly drills on each shift. The drills are conducted to prepare and train employees on the policy, communication, elopement action steps and documentation requirements. Upon completion of each drill and elopement event, the ED/HWD and/or Designee will review, discuss and document corrective actions and opportunities for elopement Drill improvement at Quarterly Quality Committee Meeting.
- ED/HWD/DPO and/or designee to ensure that all staff are trained on elopement prevention policies and instructed to perform daily checks that ensures the exit and entry doors lock and are completely secure.
- All door security codes are changed as needed if door code is compromised.
- ED/DHW and/or designee will ensure that all care staff continue to conduct hourly headcounts in Memory Care Building number 1 and sign off on each shift. Sign off sheets will be audited daily by DHW.
- ED/Associate Executive Director (AED)/DHW and/or designee will ensure that proper documentation is available and provided to the Department of Health upon request.

How the plan of corrective measures will be monitored

- The DPO will continue to perform daily door and lock checks on business days and Caregivers will continue to perform door and lock checks on weekends to ensure compliance. ED/DPO and/or Designee to review in quarterly compliance meetings.
- ED/HWD and/or Designee will audit monthly, all monthly admissions from prior month to ensure compliance. Audits on safety checks (hourly headcounts) for residents will be performed daily.

- ED/HWD and/or designee to review and audit Elopement Binders and Disaster Drills during Quarterly Quality Assurance meetings.

Date of Compliance: 11/30/2024

A401 8:36-4.1(a)(22) Resident Rights
Complaint: NJ00177021

How the plan of correction will be accomplished

- Resident #2 was affected by the deficient practice. ED/HWD and/or designee will ensure that all staff follow and comply with all resident rights. Resident Right's will continue to be posted upon entry and on the wall in Building's 1 and 2. All Resident Rights will continue to be distributed to each resident at move-in where it is explained and signed. All employees will be educated on, follow and implement the "Abuse and neglect" and the "Protecting Resident Rights" policies.

How the Community will identify other residents having the potential to be affected by the same deficient practice

All residents in Memory Care Building number one, have the potential to be affected by the deficient practice:

- HWD/RN to complete a resident elopement assessment upon move-in, semi-annually and with change in condition when diagnosis states suspected cognitive impairment.
- HWD/RN to determine resident's risk for elopement using the Elopement Risk Assessment which may include information from the resident's healthcare provider, family/responsible party, or past communications and observations. The Elopement Risk Assessment is filed in the resident's medical record.
- ED/HWD/RN and/or designee to audit all residents' charts and enforce residents' specific interventions, for residents identified at risk for elopement and documented on the resident's Service Plan. Ongoing for new residents or residents with changes in condition.
- ED/HWD and/or Designee will ensure that all employees are educated on Resident Rights and "Missing-Resident Elopement Prevention Program", policy.
- DPO removed the obstacle (couch) from in front of the exit which posed a fire hazard, on 9/14/2024. ED/DHW/RCC and/or designee to ensure that all employees are trained on fire safety and prevention and will be reviewed in monthly safety committee meetings.
- ED/DPO will ensure that all employees are educated on best practices for daily door and lock checks i.e. firmly holding the doorknob and pushing to ensure that the door is secure and exit is impossible unless unlocked by an employee.

What systemic measures have been put in place to ensure that the deficient practice will not recur

- The Director of Plant Operations (DPO) will continue to perform daily door and lock checks on business days and Caregivers will continue to perform door and lock checks on weekends to ensure that all residents enjoy their right to a safe and secure environment.
- ED, DPO and/or Designee will ensure that all doors are maintained and completely secure to ensure that Resident# 2 and all residents are not in imminent danger.
- ED/DPO will ensure that all employees are educated on best practices for daily door and lock checks i.e. firmly holding the doorknob and pushing the door to ensure that the door is secure and impossible to exit unless unlocked by an employee.
- ED/HWD or designee to ensure that a resident color photograph, a copy of the resident's emergency face sheet and completed advance directive documents, are maintained in the Elopement binder. An additional copy located in the community bus (if residents at risk of elopement ride the bus) and the Wellness Center. Photographs to be updated annually or upon a resident change in condition which may affect resident physical appearance. All staff are made aware of the location of each elopement binder by the Executive Director.
- ED/HWD or designee to ensure resident rights and elopement training are provided upon hire, during new hire orientation and annually. ED/HWD or designee will ensure that elopement drills are conducted each month to ensure quarterly drills on each shift. The drills are conducted to prepare and train employees on the policy, communication, elopement action steps and documentation requirements. Upon completion of each drill and elopement event, the ED/HWD and/or Designee will review, discuss and document corrective actions and opportunities for elopement Drill improvement at Quarterly Quality Committee Meeting.
- ED/HWD/DPO and/or designee to ensure that all staff are trained on Resident Rights and elopement prevention policies and instructed to perform daily checks that ensures the exit and entry doors lock and are completely secure.
- All door security codes are changed as needed if door code is compromised.
- ED/DHW and/or designee will ensure that all care staff continue to conduct hourly headcounts in Memory Care Building number 1 and sign off on each shift. Sign off sheets will be audited daily by DHW.
- ED/ DHW/ Resident Care Coordinator (RCC) will ensure that there is one additional care staff during 6am – 2pm shift as well as 2pm – 10pm shift.

How the plan of corrective measures will be monitored

- ED/HWD and/or designee will audit on a monthly basis, all monthly admissions from prior month to ensure compliance. Audits on safety checks for all residents will be performed weekly along with hourly headcounts done by resident care staff. ED/HWD or designee to review and audit Elopement Binders and Disaster Drills during quarterly QA meetings and ensure that all care staff and community personnel comply with the 42

Resident Rights, which will continue to be posted in front of each Building.

- ED/DPO and/or designee will ensure that logs are completed upon completion of daily door and lock checks.
- ED/DPO and/or designee will audit daily door and lock checks on a weekly basis to ensure compliance and will review during monthly safety committee meetings.

Date of Compliance: 11/30/2024

A7078:36-7.2(c) Resident Assessments and Care Plans
Complaint: NJ00177021

How the plan of correction will be accomplished

Executive Director (ED), Director of Health and Wellness (DHW) and/or Designee, will ensure that all new admissions to Memory Care Building one will undergo a thorough assessment to include elopement and exit seeking behaviors, to be completed within 24 hours post admission date.

How the Community will identify other residents having the potential to be affected by the same deficient practice

All residents in Memory Care Building number one, have the potential to be affected by the deficient practice:

- Director of Health and Wellness (DHW) completed the incident report on 9/25/2024 upon her return to work after being on PTO and will continue to ensure that all incident reports used for internal use and assessments, including and not limited to elopements are documented.
- HWD/RN to complete a resident elopement assessment upon move-in, semi-annually and with change in condition when diagnosis states suspected cognitive impairment.
- HWD/RN to determine resident's risk for elopement using the Elopement Risk Assessment which may include information from the resident's healthcare provider, family/responsible party, or past communications and observations. The Elopement Risk Assessment is filed in the resident's medical record.
- ED/HWD/RN and/or designee to audit all residents' charts and enforce residents' specific interventions, for residents identified at risk for elopement and documented on the resident's Service Plan. Ongoing for new residents or residents with changes in condition.
- ED/HWD and/or Designee will ensure that all employees are educated on Resident Rights and "Missing-Resident Elopement Prevention Program", policy.

What systemic measures have been put in place to ensure that the deficient practice will not recur

- Executive Director (ED), Director of Health and Wellness (DHW) and/or Designee, will ensure that all new admissions to Memory Care Building one will undergo a thorough assessment to include elopement and exit seeking behaviors, to be completed within 24 hours post admission date.
- Director of Health and Wellness (DHW) will ensure that all incident reports used for internal use and assessments, including and not limited to elopements, are documented.
- ED/HWD or designee to ensure that a resident color photograph, a copy of the resident's emergency face sheet and completed advance directive documents, are maintained in the Elopement binder. An additional copy located in the community bus (if residents at risk of elopement ride the bus) and the Wellness Center. Photographs to be updated annually or upon a resident change in condition which may affect resident physical appearance. All staff are made aware of the location of each elopement binder by the Executive Director.
- ED/HWD or designee to ensure elopement training is provided upon hire, during new hire orientation and annually. ED/HWD or designee will ensure that elopement drills are conducted each month to ensure quarterly drills on each shift. The drills are conducted to prepare and train employees on the policy, communication, elopement action steps and documentation requirements. Upon completion of each drill and elopement event, the ED/HWD and/or Designee will review, discuss and document corrective actions and opportunities for elopement Drill improvement at Quarterly Quality Committee Meeting.
- ED/DHW and/or designee will ensure that all care staff continue to conduct hourly headcounts in Memory Care Building number 1 and sign off on each shift. Sign off sheets will be audited daily by DHW.
- ED/ DHW/ Resident Care Coordinator (RCC) will ensure that there is one additional care staff during 6am – 2pm shift as well as 2pm – 10pm shift.

How the plan of corrective measures will be monitored

- HWD/RN to complete a resident elopement assessment upon move-in, semi-annually and with change in condition when diagnosis states suspected cognitive impairment.
- Executive Director (ED), Director of Health and Wellness (DHW) and/or Designee, will ensure that all new admissions to Memory Care Building one will undergo a thorough assessment to include elopement and exit seeking behaviors, to be completed within 24 hours post admission date.
- ED/HWD and/or Designee will audit monthly, all monthly admissions from prior month to ensure compliance. Audits on safety checks (hourly headcounts) for residents will be performed daily.
- ED/HWD and/or designee to review and audit Elopement Binders and Disaster Drills during Quarterly Quality Assurance meetings.

Date of Compliance: 11/30/2024

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
35a000 Y1	A. Building B. Wing Y2	2/7/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLERS MILL SENIOR LIVING	1674 DELSEA DRIVE DEPTFORD, NJ 08096

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 11/30/2024	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 11/30/2024	ID Prefix A0707 Reg. # 8:36-7.2(c) LSC	Correction Completed 11/30/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			